Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SPINECARE LLP
5734 SPOHN DRIVE
CORPUS CHRISTI TX 78414

Respondent Name

CHRISTUS HEALTH

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-11-3330-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier paid the claim at the wrong allowed amount. I sent an appeal to the carrier and their response was partially favorable in the fact that they increased the allowed/paid amount but they still did not pay the correct allowed amount therefore, this claim is being sent to TDI for determination."

Amount in Dispute: $1302.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of service in issue in this matter was paid correctly pursuant to DWC Rule 134.402. As this was a surgical procedure that was performed at an ambulatory surgical center, the procedure was reimbursed at 235% of the medicare fee guidelines."

Response Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2010	ASC Services for code 63685-SG-FB	$1302.67	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 12, 2010
- W1-Workers compensation state fee schedule adjustment.

Explanation of benefits dated April 4, 2011
- W1-Workers compensation state fee schedule adjustment.

Issues

1. Is the requestor entitled to additional reimbursement for code 63685-SG-FB?

Findings

1. CPT code 63650 is described as "Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling"

   Per the CMS Manual System, Publication 100-04 Medicare Claims Processing, Transmittal 1383, November 23, 2007, Section 61.3.2 - *Reporting and Charging Requirements When the Hospital Receives Full Credit for the Replaced Device Against the Cost of a More Expensive Replacement Device*, *(Rev. 1383; Issued: 11-23-07; Effective: 01-01-08; Implementation: 01-07-08)* states "When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS); and 2) receives a credit in the amount that the device being replaced would otherwise cost, the hospital must append modifier -FB to the procedure code (not on the device code) that reports the services provided to replace the device. The hospital must charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit. This charge should be billed in the covered charges field."

   The requestor appended modifier "FB" for code 63685. The "FB" modifier is defined as "Procedure code(s) that include payment for a device and the procedure is furnished without cost or for which full credit is received."

   The respondent stated that "The implant/device portion was paid to Access Mediquip." Therefore, the only issue in dispute is the service portion of CPT code 63685.

   Per ADDENDUM AA, CPT code 63685 is a device intensive procedure and is exempt from the multiple procedure rule discounting.

   Division rule at 28 TAC §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

   Per Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) reimbursement for device intensive procedure code 63685 is a two step process:

   Step 1 calculating the device portion of the procedure:

   The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 63685 for CY 2010 = $13892.45.

   This number multiplied by the device dependent APC offset percentage found in the Addendum B for National Hospital OPPS reimbursement of 85% = $11,808.58.

   Step 2 calculating the service portion of the procedure:

   The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures fully implemented ASC relative payment weight for CY 2010 = 311.4771.
   This number is multiplied by the 2010 Medicare ASC conversion factor of 311.4771 X $41.873 = $13,042.48.
   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $6521.24 ($13,042.48/2).

This number X City Conversion Factor/CMS Wage Index for Corpus Christi is $6521.24 X 0.8693 = $5668.91. The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $6521.24 + $5668.91 = $12,190.15.

The service portion is found by taking the national adjusted rate of $12,190.15 minus the device portion of $11,808.58 = $381.57.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $381.57 X 235% = $896.68.

The MAR for the service portion is $896.68. The insurance carrier paid $3601.30. The difference between amount due and paid equals $0.00. As a result, additional reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support additional reimbursement to the requestor. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/15/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.